

From the alcoholic to the sensible drinker: alcohol health education campaigns in England

Alex Mold

Introduction

For centuries, the consumption of alcohol has challenged contemporary notions of balance. From Galen and the impact of wine on the four humours, to twenty-first-century worries about ‘binge drinking’ and alcohol-related violence, too much alcohol upsets the equilibrium of the individual and the society which surrounds them. The question of how much is too much, what the consequences of excessive alcohol consumption might be, and how to deal with the results are, however, less stable. This chapter considers how the notion of balance figured in alcohol health education in England during the 1970s and 1980s. It suggests that the development of campaigns which aimed to promote ‘sensible drinking’ reflected a shift away from focusing on those already experiencing problems with alcohol, predominantly alcoholics and heavy drinkers. This move was underpinned by changes in the philosophy and practice of public health. During this period, individual behaviour was increasingly seen as both cause and cure for public health problems. The linking of practices like smoking, overeating and alcohol consumption to common conditions such as heart disease, diabetes and cancer meant that individuals and their actions became a legitimate target for public health authorities. Agreeing on the best method for promoting individual behaviour change was, however, much more problematic. Were individuals capable of taking a balanced approach to their health, or did they need to be manoeuvred into doing so?

These issues were underpinned by the evolving relationship between 'the public' and the 'self'. Focusing on a set of local health education campaigns, an expert committee report on alcohol prevention and a public consultation exercise on alcohol, the chapter highlights tensions between different approaches to dealing with drink. Health education efforts were intended to encourage individuals to moderate their alcohol consumption: to behave responsibly by becoming 'sensible drinkers'. Yet, at the same time, considerable scepticism was expressed (even by those involved in the campaigns) about the ability of health education to change behaviour. Other approaches, such as increasing the price of alcohol, were put forward as ways of reducing alcohol consumption at the population level. The apparent political and social unpalatability of such measures, however, forced a return to health education, and the 'sensible drinker' emerged as the cornerstone of alcohol health education policy.

Such an approach speaks to deeper tensions between 'the public' and the 'self' that continue to beset health education today. At first glance, the public and the self would appear to be diametrically opposed. The 'self' conjures up images of the individual: self-centred, selfish, selfie. As Michel Foucault and his followers suggested, the making of modern selves was a project concerned with individual subjectivity.¹ In contrast, 'the public' is more associated with the collective: public spirited, public good, public sphere, public services and so on. The meanings of 'the public' are multiple and contested, but these do tend to cohere around the group rather than the individual.² Publics and selves may well come into conflict, as illustrated by long-running debates in public health. In the case of vaccination, for instance, a parent's refusal to vaccinate their child may diminish herd immunity, thus placing the health of the public in jeopardy. But there are all sorts of other ways in which the self and the public intersect and even overlap. As the social epidemiologist Nancy Krieger points out, 'population' and 'individual' are not antonyms.³ We are simultaneously individuals and populations; selves and publics. The interlocking nature of the self and the public was further reinforced by the added responsibility placed on individuals for their own well-being and public health more broadly during the latter part of the twentieth century.

Some of the ways in which 'the public' and the 'self' overlapped in post-war England can be observed in the public health approach to

alcohol. There were tensions within alcohol policy between the supposed needs of the population and the individual, and the self and the public, but there were also ways in which these were mutually constitutive. The chapter will begin by considering the place of the self in post-war public health, particularly in the context of changing patterns of disease and its aetiology. The second section describes how alcohol came to be seen as a public health problem, rather than as a social order issue or purely medical concern. The chapter then moves on to look in more detail at the Health Education Council's (HEC) anti-alcohol campaign in the North East of England during the 1970s. It is suggested that a gradual change in the tactics and focus of the campaign was indicative of a shift towards focusing on the creation of 'sensible drinkers' rather than on alcoholics or heavy drinkers. This could be seen as a move away from concentrating on the imbalance associated with overconsumption and towards the promotion of moderation. The fourth section of the chapter details a contrasting approach to dealing with drink, one that focused not so much on individuals, but on the whole population. Getting everybody to drink less, it was suggested, would result in fewer alcohol problems at the population level. Yet this approach was politically controversial, and population-level measures to curb drinking were not introduced. Instead, as the final section of the chapter outlines, policy became directed towards encouraging the public to 'drink sensibly'. The production of such 'balanced selves' was riven with uncertainty and, despite many decades of policy initiatives, remains largely out of reach.

Public health, the self and individual behaviour

The post-war period was a time when the self seemed to matter in public health more than it had done in the past. Getting people to change their behaviour had long been part of health education, but in the UK and in other high-income countries the linking of lifestyle to disease prompted closer examination of individual ways of living.⁴ In Britain, the work of Richard Doll and Austin Bradford Hill in the 1950s on smoking and lung cancer was especially important in connecting individual behaviour to disease. In his classic text of 1957, *Uses of Epidemiology*, the epidemiologist Jerry Morris asserted that 'prevention of disease in the future is likely to be increasingly a matter of individual

action and personal responsibility.⁵ As the list of behaviours that were thought to bring about ill health expanded to encompass diet, exercise and alcohol, public health educators began to change their approach to communicating with the public about threats to their health. For instance, the 1964 Cohen report on health education recommended moving away from ‘specific action campaigns’, such as educating the public about vaccination, and towards areas of what it termed ‘self-discipline’, such as smoking, overeating and exercise.⁶

By the mid-1970s public health policy was increasingly orientated around the idea that individual behaviour was responsible for many public health problems, and the way to address these was through health education. As Jane Hand indicates in Chapter 4, one of the ways to deal with increasing levels of obesity was through health education. Just as with smoking, individuals could be encouraged, persuaded or frightened (depending on the tactics used) into changing their behaviour so as to improve their health.⁷ Taken together, the prioritisation of health education, the focus on managing individual risk and a new emphasis on disease prevention at the personal level was part of what was called the ‘new public health.’⁸ Such a view was predicated on a particular kind of self – an autonomous individual capable of self-government in response to expert advice.⁹ People could choose to respond to illness or maintain their health within a broader culture of ‘healthism’ that situated the problem of sickness at the individual level.¹⁰ A focus on individual behaviour thus resulted in a conception of the public as a collection of self-governing rational actors able to respond to public health messages and change their behaviours accordingly. The role of the state, from a neo-liberal perspective, was to facilitate the entrepreneurial actions of individuals rather than to create the broader social, economic and political conditions for good health.¹¹

Although individually focused health education designed to encourage personal prevention became the dominant method for dealing with public health problems, there was an alternative approach. During the 1970s and 1980s the social, economic and environmental determinants of health began to attract increased attention, especially at the global level through the World Health Organization.¹² Individual behaviour was still important as a factor in disease causation, but the proponents of a social determinants of health approach regarded behaviour as something shaped by wider political, economic, social and environmental

factors over which the individual had little control. Placing emphasis on the deeper structural underpinnings of ill health would suggest that health education alone was not enough to combat public health problems. Indeed, if we take a look at one such problem in more detail, we can see that there were tensions between those who wanted to focus on reforming individual behaviour and those who wanted to change the social environment.

Alcohol: a public health problem?

The imbalanced consumption of alcoholic beverages and their effects on drinkers was not a new area of government concern in the 1970s. Alcohol had posed problems in terms of public order, and danger to health and morality for centuries. During the nineteenth century, the habitual consumption of alcohol came to be seen as the disease of 'alcoholism', comprising both medical and moral elements.¹³ There were public health dimensions to the alcohol issue, especially around the impact drinking had on industrial production, but drink was not seen as a public health problem. The temperance movement, for instance, rarely intersected with those pressing for sanitarian reform.¹⁴ It was not until the 1950s, when there was an apparent rise in the number of alcoholics, that the disease-based view of alcoholism was 're-discovered', prompting the establishment of dedicated treatment units for individuals with alcohol problems.¹⁵

A wider appreciation of the difficulties that alcohol could cause began to emerge in the 1960s. Initially, the focus was on drink driving. Measures such as the introduction of the breathalyser in 1967 were designed to protect the public from intoxicated drivers and reduce the number of car accidents.¹⁶ Towards the end of the decade, a more distinct public health view of alcohol problems started to appear. This was prompted by a marked growth in alcohol consumption during the 1960s and 1970s, and with it an increase in alcohol-related illnesses such as cirrhosis of the liver.¹⁷ Alcohol consumption almost doubled between 1950 and the mid-1970s, rising from 5.2 litres of pure alcohol per person to 9.3 litres.¹⁸ Deaths from liver cirrhosis increased from just over 20 per million in 1950 to more than 40 per million by 1970.¹⁹ Alcohol clearly posed a danger to public health, but it was not the established authorities and institutions in public health policy-making

and practice that pushed alcohol onto the public health agenda. Instead, a distinct 'alcohol policy network', made up of doctors and researchers who specialised in alcohol and addictions, voluntary organisations and sympathetic civil servants, was instrumental in getting the government to take alcohol issues seriously.²⁰ This alcohol policy network was able to take the lead in defining alcohol as a public health issue because the traditional bastions of public health practice and policy-making were in disarray in this period. The key public health official, the Medical Officer of Health (MOH), had undergone a gradual diminution in status following the establishment of the NHS.²¹ The position of MOH was abandoned altogether when public health services moved out of local government following the reorganisation of the health service in 1973, although it was later replaced with the Director of Public Health role when public health 'returned' to local government in 2012.²² Academic public health was also undergoing significant change, most notably around the uses of epidemiology to demonstrate causal links between behaviour and disease.²³

Indeed, it was an epidemiological view of alcohol consumption that helped redefine alcohol as a public health issue. Key members of the British alcohol policy network championed a thesis first put forward in 1956 by the French demographer Sully Ledermann.²⁴ Ledermann argued that the level of alcohol consumption in a population was related to the extent of alcohol problems in that population. As the total amount of alcohol consumed increased, so too did the number of individuals with alcohol problems such as alcoholism and cirrhosis of the liver. Reducing the amount of alcohol consumed by everyone, whether a problem drinker or not, would result in better health outcomes overall. Moderation was thus not only a desirable individual goal, but an important collective one too. This epidemiological approach to alcohol prompted a series of government reports and investigations by medical professional bodies throughout the late 1970s and early 1980s. As will be discussed further below, there was some support for the idea that tax should be used to increase the price of alcohol (or at least not let it decline further in real terms) so as to decrease population-level consumption, and therefore alcohol-related harms. Such an approach was controversial: a report produced by a government think tank that had suggested the use of taxation to control the price of drink was suppressed.²⁵ The government was reluctant to use tax policy in this way

and fearful of the economic impact such measures would have on the drinks industry, tax revenue and jobs.

Nonetheless, something needed to be done about alcohol problems. The apparent solution was to focus on health education. Here was something that all parties, including health professionals, government and the alcohol industry, could agree on. Health education was unlikely to have a significant impact on the revenue generated from alcohol sales, nor would it be politically or publicly unpopular. Yet this supposed 'island of consensus' was really a mirage.²⁶ A close examination of the development of alcohol education in the 1970s demonstrates that there was a good deal of conflict, not only between the interested actors but also around the appropriate target: should this be the individual self or the wider public?

The HEC's North East campaigns on alcohol education, 1974–81

In the early 1970s, the newly established Health Education Council (HEC) decided to mount a health education campaign on alcohol. Such a move can be explained by the growing concern in government about alcohol problems, but was also rooted in the HEC's view of public health and its role in promoting it. The HEC saw health as 'more than bodily fitness – that ultimately our concern was to help people live in a state of harmony with themselves and with the community as a whole.'²⁷ Alcohol problems fitted within this balance-orientated approach. In November 1973, the HEC agreed to run a pilot anti-alcohol campaign in the North East of England.²⁸ The Council was tasked with delivering health education nationally and locally, although most of their work at the local level was restricted to providing information, leaflets and guidance to local authorities.²⁹ The North East campaigns on alcohol were different: they were intended to test the approach before rolling the programme out to other regions. Why the North East region was chosen for the pilot is unclear. The fact that the area had the highest alcohol consumption levels for men in the UK was later used to justify its selection, although this irritated local service workers who felt that problems in the North East were no worse than anywhere else in the country.³⁰ The selected region was also coterminous with the boundaries of the Area Health Authority and the Tyne Tees television area, facilitating the distribution of TV advertisements. The HEC's alcohol

education programme in the North East was divided into three distinct phases. The first was in 1974; the second between 1977 and 1979; and the final phase occurred in 1981. Each campaign adopted a different approach, and the difficulties encountered reveal varied aspects of the problems underpinning alcohol health education.

'Everybody likes a drink. Nobody likes a drunk.', 1974

The first stage of the HEC's anti-alcohol programme began in October 1974. It aimed to increase professional awareness of alcohol problems and to establish the feasibility of health education about alcohol problems.³¹ The campaign cost £88,000, with £60,000 being spent on TV, press and poster advertisements.³² The campaign material was designed by the advertising agency, Saatchi & Saatchi. The HEC had used Saatchi & Saatchi previously to create health education material, including a controversial image of a naked pregnant woman smoking.³³ The advertisements that the agency designed for the anti-alcohol campaign were equally provocative. Based around the tag line 'Everybody likes a drink. Nobody likes a drunk.', the advertisements attempted to convey some of the dangers of heavy drinking; the signs and symptoms indicative of problems due to heavy drinking; and where to get help.³⁴ The posters used for the campaign were stark and simple, with no visual imagery beyond the slogan itself, and a further exhortation to 'Drink in moderation' and not 'let alcohol go to your head'. The HEC felt that the central slogan 'would be a powerful and positive message to adopt, without exposing the Council to accusations of being killjoys'.³⁵ Yet, not everyone agreed. Local psychiatrist Anthony Thorley argued that the slogan was 'criticised and misunderstood by many North-easterners. Not everybody does like a drink. People are not all agreed as to what a "drunk" is. One man's "sensible drinking" is another man's stupidity'.³⁶ The Medical Council on Alcoholism and the Alcohol Education Centre also objected to the tag line, preferring 'Almost everybody likes a drink'.³⁷

Criticism of the campaign went beyond its tag line. The campaign was intended to be a piece of primary prevention – that is, it was designed to stop alcohol problems from developing. Yet the focus of the advertisements, and even the way that the agency and the HEC described the campaign, suggested that the target group was those already using alcohol excessively, such as alcoholics and heavy drinkers, rather than

**Everybody likes
a drink.**

**Nobody likes
a drunk.**

Drink in moderation. Don't let alcohol go to your head.

If you're worried about the amount you drink, see your doctor or contact:
The North East Council on Alcoholism, Mea House, Ellison Place, Newcastle upon Tyne, NE1 6XS Tel: Newcastle upon Tyne 20797


The Health Education Council

3.1 'Everybody likes a drink. Nobody likes a drunk.' Saatchi & Saatchi for the Health Education Council, 1974

the general population. The HEC tended to refer to their efforts as the 'anti-alcoholism campaign' and saw the fact that over 900 people contacted treatment services in the wake of the campaign as a sign of its success.³⁸ On the ground in the North East, local alcohol agency workers were less convinced. Services were overwhelmed and they

lacked the capacity to assist everyone who came forward for help.³⁹ An evaluation of the campaign suggested that while penetration was high there was little lasting change in attitudes towards drinking or drinking behaviour.⁴⁰

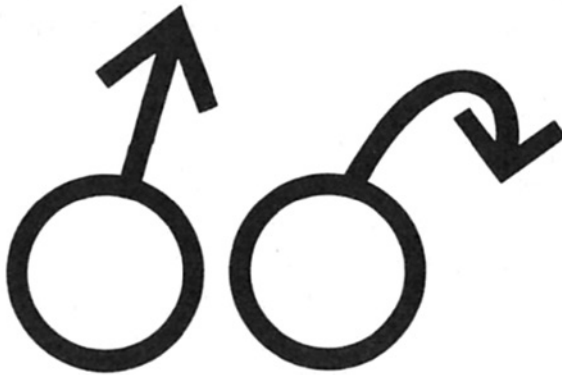
'It's always the boozer who's the loser', 1977–79

The HEC took on board some of the criticisms made of the 1974 campaign when designing a second phase, which ran between 1977 and 1979. This stage of the campaign had similar aims to the first phase, and initially used the same material, but later developed new resources under the slogan 'It's always the boozer who's the loser.' Fresh visual and audio-visual material was commissioned by the HEC, which again made use of Saatchi & Saatchi. The agency produced 'playlets' which were shown on Tyne Tees TV and in local cinemas. These advertisements were criticised by local agencies, which regarded them as still too focused on alcoholics rather than on everyday drinkers. Moreover, the campaign betrayed a lack of understanding of the local population. Voices of the actors in the advertisements had Yorkshire accents rather than those of people from the North East, and the content of the commercials was too geared to a 'middle class view of life.'⁴¹ Thorley argued that one of the posters, which featured a picture of manicured female hand reaching for a bottle of vodka, was a 'jet-set' image that did not resonate in the North East. Another poster focused on the effect that alcohol could have on men's sexual performance. Making use of the universal symbol for male, the poster suggested that having too much to drink could result in erectile dysfunction, or 'brewer's droop'. The poster won an advertising prize, but not everyone viewing the poster understood the symbols.⁴² Thorley suggested that 'in the North-east the vast majority of people had no idea at all what the symbols represented. One wit even queried whether it represented a crashed Volvo car!'⁴³

Another poster featured an image of a crying child. Her dirty, bruised face was streaked with tears, and the strapline read: 'Eight pints of beer and four large whiskies a day aren't doing her any good.' Once again, Thorley felt that the image was misunderstood, and though the poster 'became well known throughout the region' a 'minority thought it was the *girl* who had been drinking!'⁴⁴

Misunderstood or not, these posters indicated a change of tactics and focus. Both posters appealed to the emotions of the viewer in order

**If you drink
too much there's
one part that every
beer can reach.**



Your health isn't the only thing which suffers if you over-drink. A night of heavy drinking can make it impossible for you to make love.
And even if you think your drinking isn't affecting you, have you ever wondered how it might be affecting your partner?
Put it this way: How would you like to be made love to by a drunk?
Everybody likes a drink. Nobody likes a drunk.



The Health Education Council Helping you to better health

- 3.2 'If you drink too much there's one part that every beer can reach.'
Saatchi & Saatchi for the Health Education Council, 1979



3.3 'Eight pints of beer and four large whiskies a day aren't doing her any good.' Saatchi & Saatchi for the Health Education Council, 1979

to provoke reflection on the amount of alcohol s/he consumed. The 'brewer's droop' poster made use of humour to encourage the viewer to think about the consequences of heavy drinking for themselves and for their sexual partner. The 'battered child' poster focused on the damage alcohol could cause to an 'innocent victim', a trope found in nineteenth-century temperance material and in more contemporary public health campaigns, such as those around smoking.⁴⁵ The posters drew attention to the wider consequences of alcohol consumption, beyond the individual drinker themselves, thus emphasising the social dimension to the alcohol problem, rather than purely the medical one. This was reinforced by the impression that the posters appeared to be aimed at ordinary (albeit 'heavy' or 'excessive') drinkers rather than alcoholics.

The second phase of the campaign came to an end in 1979. According to an evaluation of the campaign, the HEC reported that it had decided to abandon its efforts due to lack of action and coordination on the ground, something denied by those in the North East.⁴⁶ Thorley contended that by '1979 it was clear that the media work, now costing almost half a million pounds, was ineffective and increasingly embarrassing to all concerned.'⁴⁷ For their part, Saatchi & Saatchi were also dissatisfied with the campaign, finding the central brief, to focus on encouraging moderation in drinking, a difficult task to fulfil.⁴⁸ Indeed, the campaign material gave little indication as to what 'moderate' drinking consisted of. The 'battered child' poster did appear to suggest that eight pints of beer and four large whiskies a day was 'too much', but setting limits to alcohol consumption formed a more central part of the campaign's third phase, in 1981.

'Why spoil a good thing?', 1981

The final stage of the HEC's anti-alcohol campaign in the North East was framed around a desire to promote 'moderate drinking'. Those involved in devising the campaign wanted it to focus on heightening awareness of alcohol problems rather than cutting the consumption of alcohol *per se*.⁴⁹ The HEC dropped Saatchi & Saatchi, and instead made use of a Newcastle-based advertising agency, Redlands. The agency devised new campaign materials featuring local TV presenter and botanist, David Bellamy. Bellamy was chosen by Redlands because they felt that he would be seen by the public as intelligent and honest, but would

also be able to connect with the intended audience as he was from the North East and a drinker himself.⁵⁰ The advertisements offered guidance on how much alcohol was 'too much' (five pints of beer or more) and also suggested a level of moderate consumption as being 'something like two or three pints two or three times a week'. Indeed, the benefits of moderate alcohol consumption were tacitly acknowledged by the campaign's tag line, 'Why spoil a good thing?'

The Bellamy campaign also offered a more precise sense of how balance in relation to alcohol could be calculated than the previous posters. Some saw the campaign's issuing of guidance on levels of alcohol consumption as more informative and less moralising than previous messages.⁵¹ The promotion of moderation in consumption, whether it be of alcohol or other foodstuffs, was nothing new, but the setting of drinking limits was controversial.⁵² There was little agreement among experts about what a 'safe' level of drinking consisted of. In their 1979 report, the Royal College of Psychiatrists suggested that four pints, four double whiskies or one bottle of wine a day 'constitute reasonable guidelines of the upper limit of drinking'.⁵³ Other experts were concerned that setting an upper limit would encourage people to drink up to that level in the belief that their behaviour could do no harm.⁵⁴ Yet others insisted that, although there was no clear evidence about what amount of alcohol increased the risk of particular conditions and by how much, guidelines were helpful as a way of changing attitudes to drinking.⁵⁵ Indeed, devising guidance around safe alcohol consumption limits became a feature of alcohol policy in the mid-1980s, but this campaign was one of the first to attempt to communicate information about 'sensible drinking' to the wider public.

A survey conducted in the North East following the Bellamy campaign suggested that the core message around moderate drinking did get through to the local population. More than two-thirds of the 750 people interviewed recalled the campaign, and all but four could remember something relevant when questioned about the main message of the campaign. When asked if the campaign had changed their behaviour, 12.7 per cent claimed that it had, but only three people said that they had tried to drink less.⁵⁶ As an evaluation of the campaign pointed out, it had not been designed to change behaviour and, based on its original goal of raising public awareness about moderate alcohol consumption, the campaign could be judged a modest success.⁵⁷ However, the HEC's

If you're drinking five pints of beer or more every day, it's just too much for your own good.


Drinking too much too often is one of the causes of a type of heart disease doctors call cardiomyopathy. It can also give you a stomach ulcer. And liver trouble.

Too much?

When you top the 5 pints mark you're drinking too much. You're starting to attack your heart, your stomach, your liver. And you could pay the price.


Stick to something like two or three pints two or three times a week. (And for your information that's equivalent to drinking two or three double whiskies two or three times a week.) Stick to something like that and you could be enjoying a drink when you're eighty-five.

Why spoil a good thing?



David Bellamy
**David Bellamy,
Co. Durham**

If you'd like more facts and information about drink and drinking, contact N.E.C.A., Mea House, Ellison Place, Newcastle upon Tyne NE1 8XS. Tel: Newcastle 20797

 **The Health Education Council**
Helping you to better health

Why spoil a good thing?

3.4 'If you're drinking five pints of beer or more everyday...' Redlands for the Health Education Council, 1981

paymasters, the Department of Health and Social Security (DHSS), were less convinced. The department and its ministers were aware that changing behaviour was challenging and time-consuming. In 1981, the Secretary of State for Social Services, Patrick Jenkin, told a meeting of the National Council on Alcoholism that it 'is difficult to modify social attitudes and difficult to measure what, if anything, has been achieved. Health education is a long haul.' But he also remarked that at 'a time when money is clearly limited, Ministers and all concerned need to be convinced that the available resources will be used to good effect'.⁵⁸ The HEC was under pressure to demonstrate the cost-effectiveness of its work but was unsure that alcohol health education would reduce alcohol consumption, at least directly. The Council's alcohol programme strategy for 1982–83 argued that many forces influenced alcohol consumption, and as a result 'health education **by itself** [original emphasis] has only a limited ability to reduce it'. Other measures, such as greater control of alcohol, and aiming to reduce per capita consumption, also had a part to play in dealing with alcohol-related harm.⁵⁹

Taken together, the three phases of the HEC's alcohol education campaign in the North East point to an evolution in targets, techniques and tactics. In the first phase of the campaign, the target group seemed to be alcoholics, or the 'drunk'. In the second phase, the target group was the 'heavy drinker'. In the final phase, it appeared that a wider drinking public was the target, with the desire to promote 'sensible' or 'moderate' drinking. This represented a shift away from concentrating on what might be termed 'pathological' drinking and towards focusing on the health consequences of alcohol in the 'normal' population. Such an approach could be seen as a precursor to that advocated by the epidemiologist Geoffrey Rose a few years later.⁶⁰ Rose argued that the greatest amount of ill health was experienced not by those at high risk, but by those in low-risk groups, simply because there were more of them. Prevention strategies should therefore target the whole population, lowering the risk for everyone, not just those in high-risk groups.⁶¹ This kind of approach could also be read in the changing techniques used in the campaigns, with humour and emotional entreaties giving way to a more 'rational' approach, appealing to the drinker as a 'sensible' individual able to moderate their behaviour. Such varying techniques spoke also to varying tactics, with a more specific sense of the kinds of behaviour that should be encouraged or discouraged emerging by the end of

the period. These shifts reflected broader developments at the policy level that will be explored in the remainder of the chapter, but at the same time there was also a lack of confidence about health education itself. Significant doubts were expressed, not least by the HEC, about the ability of health education to shrink alcohol consumption. Other means, such as reducing drinking at the population level, seemed to offer a solution.

The report of the Advisory Committee on Alcoholism on *Prevention*, 1975–77

The best way to prevent the development of alcohol problems, including the role of population-level measures and health education, was examined by several expert committees in the 1970s. A key report, titled *Prevention*, was produced by the Advisory Committee on Alcoholism (ACA), which was established in 1975 to advise the government on the provision of services relating to alcoholism. According to Betsy Thom, its terms of reference were vague, allowing the Committee to interpret their brief widely, examining not only treatment services, but also the prevention of alcohol problems.⁶² As a result, the ACA was interested not only in alcoholics and heavy drinkers, but also those who might develop drinking problems, and the consumption of alcohol in the population more broadly. In its report, the ACA argued that ‘we have to consider not only the affected individual, those who come into contact with him, and vulnerable groups, but also deep rooted attitudes, assumptions and traditions which blind people to the wide range of problems caused by alcohol misuse’.⁶³

The ACA’s expansive interpretation of the potential damage that alcohol could cause led it towards a broad understanding of the ways in which such problems could be prevented. The Committee’s decision to focus on prevention was, however, ‘against the Chairman’s wishes and our [the DHSS] advice’. The DHSS was well aware that the ACA was likely to stray into areas that were the concern of other government departments, such as the Ministry of Agriculture, Fisheries and Food (MAFF), which it saw as ‘the sponsoring department for the drinks industry’.⁶⁴ A particular flash point was the Ledermann thesis and the notion that introducing measures to decrease alcohol consumption throughout the population could reduce drink problems. At the ACA’s

first meeting, members accepted Ledermann's arguments, stating that 'the available facts pointed strongly towards the need for a reduction in per capita consumption of alcohol as one of the objectives of any preventive strategy'. But at the same time, the Committee was also aware of the potential political and social consequences of such an approach. It noted that 'Increasing the price of alcohol in real terms to a point where consumption was substantially affected would be difficult politically and might cause secondary poverty.'⁶⁵ Such a view implied that some drinkers were capable of responding to price increases in a rational manner by reducing their consumption, but others were thought likely to continue to drink at the same level, even if this resulted in poverty. As a result, the Committee did not suggest any changes to fiscal controls or the licensing laws; instead it recommended that 'alcohol should not be allowed to become cheaper in real terms.'⁶⁶

Alongside this moderate form of price control, the Committee proposed that more effort be put into health education. In the final report, the ACA recommended that 'Health education designed to alert people to the dangers of alcohol and to discourage excessive drinking should be encouraged and expanded.'⁶⁷ In the discussions leading up to the publication of the report, however, health education had occupied a more controversial position. The psychiatrist and addiction researcher Griffith Edwards 'had considerable reservations about any campaign which attempted to change people's behaviour' as he was sceptical about the effectiveness of alcohol treatment and counselling services. Edwards was instead in favour of the introduction of greater controls on the price and availability of alcohol, and he suggested that 'any campaign which was mounted should attempt to educate the public about the need for controls over the availability of alcohol as a means of preventing alcoholism.'⁶⁸ Not everyone on the Committee agreed, and at a later meeting (where Edwards was absent) they moved towards an approach that emphasised 'safe' or 'healthy' drinking.⁶⁹ The Committee expressed some doubt about the 'value of referring to "healthy drinking" or "safe drinking levels"' as 'the message conveyed was so complex that it seemed likely to be misunderstood.'⁷⁰ Nonetheless, the ACA report did touch on the issue, suggesting that there was a need to 'define a level of heavy drinking and to discourage drinking above that level'. It even made a tentative suggestion as to what this level should consist of, noting that a daily intake of 15 cl of ethanol, equivalent to about

half a bottle of spirits or 8–10 pints of beer, was ‘generally regarded as unsafe.’⁷¹

The ACA’s provisional approach, and reluctance to either offer firm guidelines on ‘safe drinking’ or wholly endorse stronger population-level control measures, was a result of its recognition that such issues were ‘controversial’ and ‘sensitive’. The Committee was unsure about the extent to which it was ‘justifiable to interfere with the activities of drinkers on account of those who may cause or come to harm’. Political concerns were just as, if not more, important than scientific uncertainty about ‘safe’ drinking levels or the Ledermann thesis. The issue was not ‘thought to be one on which a Government could impose its will without paying the most careful regard to the views of the people.’⁷² As a result, the ACA argued that ‘stricter controls cannot and should not be introduced without informed public discussion’. Moreover, the ‘problems resulting from alcohol misuse have not yet been widely enough discussed: we believe that the public should be given more information, including an estimate of the true cost of alcohol misuse to society so that it can reach a realistic view of the restraints that should be placed on drinking.’⁷³ This approach was also endorsed by the DHSS’ booklet, *Prevention and Health: Everybody’s Business*, which stated that ‘The best combination of strategies for our society, and the attitudes to alcohol which should be encouraged in it, are matters which deserve public discussion.’⁷⁴

Indeed, some level of public debate about alcohol health education campaigns was already taking place. Most of the broadsheet newspapers simply summarised the key findings of the ACA’s report, but some of the more libertarian publications offered editorials on the wider issue of health education. An article by Colin Welch in the *Daily Telegraph* was highly critical of government-backed health education efforts against smoking and drinking, which he saw as a ‘sinister step towards tyranny’. Taylor asserted that ‘When the British people imposed on the State the duty of caring for all our ailments free of charge we forgot that wise adage – *there is no free lunch* ... For the State at that very moment acquired the right to order us to live healthy lives – to eschew this or that substance or practice.’⁷⁵ ‘Peter Simple’, also writing in the *Daily Telegraph*, took a similar tack. He stated that government plans to put a health warning on the labels of alcoholic drinks was an ‘idiotic message’ and a ‘symbol of bureaucratic welfarism.’⁷⁶ Others in the media,

however, were less critical of such an approach. Reporting on a speech made by the Minister of Health and Social Services, David Ennals, where he had asked whether or not alcohol problems should be tackled more 'vigorously', *The Economist* responded: 'The answer surely is yes: and for a start his [Ennals'] advisory committee on alcoholism has suggested preventive measures that would not conflict with the enjoyment of normal drinking.'⁷⁷ It is impossible to know the extent to which the wider public shared the views expressed by 'Simple' and Taylor, but their presence suggested that there was some level of feeling that introducing stronger control measures on alcohol might be an unacceptable restriction of liberty, something the ACA itself had acknowledged. There was a perceived need for public debate about the approach to be taken to alcohol, and the extent to which individual drinking should be curbed for the public good.

Drinking Sensibly, 1977–81

An opportunity for dialogue about the response to alcohol was provided by a 'nationwide debate' initiated at the end of 1977. When launching the debate, Ennals said that there were questions about alcohol that 'we must all ask ourselves'. Was it the role of government, he wondered, 'to concern itself with personal behaviour – or do you believe the Government has a duty to represent the interests of the community and seek to contain a growing ill?' Should government, Ennals inquired, 'impose a much bigger tax on all intoxicating drink as a deterrent to drinking, or would this be unfair to the majority who are sensible drinkers?'⁷⁸ A 'consultative document', to be prepared by the DHSS, was intended to 'outline for discussion the arguments for and against various possible preventive measures' and it was hoped that 'the ensuing debate will assist the Government to draw up firm proposals for improvement.'⁷⁹ Work began on the document in 1977, with publication intended for the following year, but it took until 1981 for the final report, *Drinking Sensibly*, to appear.

The long gestation of *Drinking Sensibly* was the result of significant interdepartmental tension. The central difficulty surrounded the control of alcohol prices, the impact that this would have on consumption, and whether taxation should be used to increase the price of drink. Not everyone in the DHSS was convinced of the Ledermann thesis, but key

officials and the Minister were of the opinion that ‘there is sufficient evidence available to link price, consumption and damage as to make it desirable that drink in all its forms should not become *cheaper* [original emphasis]’.⁸⁰ Such views found their way into an early draft of the consultation document. The document stated that: ‘There seems little doubt that lowering the price of alcoholic drink does tend to encourage greater consumption, while raising prices leads to a fall-off in the amount people drink.’ The draft was equivocal on whether tax should be used to increase price – this was for the government and the wider public to decide – but the document implied that inexpensive alcohol meant that the problem would worsen: ‘Cheaper and cheaper drink prices would severely hamper efforts through health education and other means to tackle the problem of alcohol misuse and perhaps make all such efforts abortive.’⁸¹

Other government departments did not share this view. In a similar way to the discussion of flight time limitations examined by Natasha Feiner in Chapter 7, economic and business concerns could trump public health. The Department of Trade, Customs and Excise, MAFF, the Home Office and the Treasury all had difficulties with aspects of the draft text on alcohol taxation and price disincentives. As a letter from an official at Customs and Excise noted, it ‘is clear that this chapter [on tax and price control] raises issues about which there is considerable disagreement between Departments.’⁸² The Department of Trade was concerned about ‘the practicability and desirability of seeking to hold down the consumption of alcohol through action on prices, and the implications for competition and consumer choice of any more restrictive approach to licensing.’⁸³ MAFF wanted the document to recognise the importance of the drinks industry to the economy, and to ‘avoid suggesting that there is one single problem that can be dealt with by general solutions’. Such ‘general solutions would penalise unfairly the majority of sensible drinkers and without any guarantee that the number of problem drinkers would be reduced.’⁸⁴ The Treasury sought to delay release of the document, and possibly prevent it from being published at all. The change of government in May 1979 offered an opportunity to ‘seek guidance from Ministers before a great deal of additional effort is put into revising the present draft’. Treasury officials noted that the ‘first question is whether the present Government will wish to publish any document along these lines; and we for

our part would want to recommend to our Ministers that they should consider carefully the policy implications before coming to a firm decision.⁸⁵

The consultative document survived, but in a significantly modified form, and only after it was approved at Cabinet level. The section on price and tax was rewritten substantially. No direct comment was made about the link between price and consumption; instead the final document summarised the recommendations made by other committees and reports, such as the ACA's *Prevention*.⁸⁶ The document was unequivocal, however, on the issue of taxation: 'Taking account of the economic as well as the health and social considerations, and bearing in mind the practical difficulties involved', it argued, 'the Government cannot accept recommendations that have been made for the systematic use of tax rates as a means of regulating consumption.'⁸⁷ The possibility of using taxation to control the price of drink was not up for discussion. Indeed, the overall tone of *Drinking Sensibly* was not as 'consultative' as originally intended. Although the text was billed as a 'discussion document', it was unclear how exchange would take place. Instead, *Drinking Sensibly* was intended to 'help clarify public views' and offer 'statements of the government's position.'⁸⁸

In any case, it does not seem that *Drinking Sensibly* stimulated much public debate. The DHSS had intended the document to 'be aimed at the intelligent layman, in the hope that the Press and TV will be sufficiently interested to follow up some of the points and so reach a wider audience.'⁸⁹ Yet they decided to publish the document with a plain cover, since the anticipated readership was 'the influencers of opinion' rather than 'impulse buyers.'⁹⁰ The media did report on the publication of *Drinking Sensibly*, but most newspapers just summarised the document's key statements and highlighted the fact that the government was not recommending an increase in the tax on alcohol. The *Guardian* was alone in sounding a critical note: 'The Government is to take no direct action – either by tax increases on alcohol or by curbing drinks advertising – to halt a dramatic rise in the misuse of alcohol.' Instead, the 'drive to curb abuse would rely entirely on voluntary effort.'⁹¹ The only other source of criticism came from the medical press. The psychiatrist and addiction expert Thomas Bewley, writing in the *British Medical Journal*, summed up his views as 'Drinking sensibly, perhaps. Thinking sensibly, no.'⁹²

Although provoking little public debate at the time, the report, and especially the notion of ‘drinking sensibly’, was important. The DHSS pondered long and hard over the title of the document. Alternatives included ‘Responsible Drinking’, ‘Sensible Drinking’, ‘Sensible Attitudes to Drinking’, ‘Preventing Alcohol Misuse’ and ‘Alcohol – The Right Balance.’⁹³ Other suggested titles were less than serious, perhaps because they were developed in the run-up to Christmas 1979. It seems unlikely that ‘Not Only Mother’s Ruin’, ‘Don’t Trifle With Sherry’, ‘I Drink Therefore I Am’ or ‘Steady as she Flows’ were ever in contention, but the debate over the title of the consultative document does draw attention to the way in which alcohol consumption was framed by the text.⁹⁴ Although ‘Drinking Sensibly’ emerged as the victor, this was not defined in the final document. The text referred to ‘sensible attitudes towards the use of alcohol’, but it was not at all clear what these were.⁹⁵ *Drinking Sensibly* mentioned the Royal College of Psychiatrists’ suggestion that drinkers limit themselves to no more than four pints of beer, or four double spirits, or one bottle of wine a day, but the report also pointed out ‘drawbacks’ to such an approach, such as the varied effect of alcohol on different people. The ‘sensible drinker’ may have been synonymous with the ‘responsible citizen’, who ‘must consider in the light of these facts what they themselves can do to limit the harm to their own health and the health of others.’⁹⁶ The rationality of the self was being appealed to, not only to protect his or her own health, but also that of the wider public.

Conclusion

At the time of publication of *Drinking Sensibly*, the concepts of ‘moderate drinking’ and the ‘sensible drinker’ seem to have been still in development, but they came to hold significance in the later evolution of alcohol policy and alcohol health education. On a practical level, a more specific notion of what sensible drinking consisted of in terms of the amount of alcohol consumed began to develop in the latter half of the 1980s. Suggested daily limits had already been proposed by the Royal College of Psychiatrists, but in 1984 the HEC issued a pamphlet setting out the ‘safe limits’, to which people should restrict their drinking. ‘Safe limits’ for drinking were defined as eighteen ‘standard drinks’ (equivalent to half a pint of beer, a small glass of wine or a single measure of

spirits) a week for men and nine for women.⁹⁷ In 1986 and 1987 the Royal College of Psychiatrists, the Royal College of Physicians and the Royal College of General Practitioners each published reports on alcohol, and all recommended that 'sensible limits of drinking' consisted of not more than twenty-one 'units' of alcohol a week for men, and not more than fourteen units a week for women. A unit of alcohol was equal to 10 ml or 8 g of pure alcohol, or about half a pint of beer.⁹⁸ In January 2016, the recommended weekly limit for alcohol consumption for men (previously twenty-one units) was brought into line with that of women (fourteen units).

Fluctuations in the recommended levels of alcohol consumption over time, and the fact that many individuals continue to exceed these limits, suggests that 'sensible drinking' was a mutable concept not a fixed category.⁹⁹ Nonetheless, alcohol policy has continued to encourage individuals to strive for a sense of balance in their drinking. Population-level arguments about alcohol consumption have reappeared, but as disputes over the introduction of minimum unit pricing in England make clear, such measures are bitterly contested.¹⁰⁰ Public health policy and practice around alcohol continues to centre on health education – on persuading individuals to alter their drinking behaviour. Whether such measures 'work' is still open to question. There is evidence to indicate that health education can help push alcohol problems up the public and political agenda, but there is little to suggest that health education alone can change drinking behaviour.¹⁰¹

In a sense, however, the debate about whether health education works misses a more fundamental point. The promotion of such a strategy was the result not only of the activities of vested interests, like the alcohol industry, but part of a more complex negotiation over the question of balance between the 'public' and the 'self' and the relationship between them. On one level, the continued appeal to the drinker to consume alcohol 'sensibly' seems like a victory for the notion of a self-orientated approach to public health problems. The controversy around measures such as minimum unit pricing, designed to increase the cost of alcohol, also points to a reluctance to address the environmental and structural factors that facilitate overconsumption. Alcohol policy is thus another example of public health's focus on the individual and their behaviour as both cause of, and remedy for, public health problems. Sensible drinking, was not, however, solely about health,

but about balancing public and private interests in other spheres too. The ability of the alcohol industry to produce and sell alcohol, and the liberty of the individual to consume it, needed to be taken into account even if there were health consequences. Exhortations towards self-regulation were not necessarily a tool of social or political control but could also operate as a way to balance competing interests, albeit imperfectly.

Indeed, there are all sorts of ways in which the self and the public continue to be mutually constitutive. In alcohol policy, as in so many areas of public health, the self being imagined is required to act for the public as well as individual good. As with any attempt to control behaviour, a moral element can be detected. Alcohol policy is not applied evenly, with women and young people tending to come off worse, despite consumption being the highest among middle-aged, middle-class men.¹⁰² Yet alcohol does cause damage to health, and reducing individual consumption would have population-level benefits. An appeal to selves has become a necessary part of any public health strategy. That is not to say that public health should ignore the wider structural and environmental factors that underpin health and well-being. But here again the self makes an appearance: one of the reasons minimum unit pricing has been so contested is because of a concern that it would be seen to penalise individual drinkers by raising prices. It has now become difficult to think about public health problems without also thinking about the selves that experience them. The self and the public have become intertwined to such an extent that it is no longer always possible to separate them.

Elegies for the public, or rather a specific vision of it, are not hard to find. Ever since (and long before) Margaret Thatcher said that there is no such thing as society, 'the public' has been seen to be in decline.¹⁰³ This line of argument, however, can be pushed too far. After all, the public is an elastic concept: if it can be broadened from the elite white men of Habermas's public sphere to include women, the working classes and ethnic minorities, accommodating the self-governing individual should be possible.¹⁰⁴ And just as we can observe multiple signs of the hollowing out of the public, there are all sorts of ways in which it persists. Public health cannot exist without a public. Until public health becomes self-health, there will continue to be a place for both the public and the self.

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